July 26, 2019

Mr. Ajit Pai, Chairperson
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: FCC 19-64

Dear Chairperson Pai,

Hathaway-Sycamores is writing to comment on the Notice of Proposed Rulemaking (NPRM) regarding the $100 million Connected Care Pilot (CCP) program that would assist low-income patients and veterans stay directly connected to health care providers through telehealth services. As a non-profit organization that provides mental health services and support to Medi-Cal beneficiaires in Los Angeles County, we have experience in utilizing telehealth for a subset of our consumers to receive care from their respective psychiatrists. Based on this experience, telehealth enables us to delivery timely care to consumers while offering a workforce solution due to the national shortage of qualified child psychiatrists. For these reasons, we believe that this Connected Care Pilot program will inform the federal government's understanding of how broadband-enabled technology can enhance continuity of care and access to services to low-income communities living in rural areas and positively impact health consumers' outcomes.

In the following sections, we outline our responses to the most relevant questions published in the July 11th Notice of Proposed Rulemaking.

Is there a generally acepted authority that provides a definition of "health condition" that would be appropriate to adopt for the Pilot Program?

We agree with the FCC's preliminary thoughts to limit the Pilot program to proposals that largely focus on health conditions that typically require at least severatl months or more to treat. We wish to emphasize the importance of including mental health and substance use disorders. According to the National Institute of Mental Health, in 2017, approximately 44.6 million adults in the United States had some type of mental illness. The consequences of untreated mental health to the U.S. are staggering; estimates by National Alliance on Mental Health indicate the amount to be as high as $300 billion annually due to lost productivity. Given the cost to society of untreated mental health and the current crisis from opioids, we support the inclusion of mental health and and substance use disorders in a broad definition of health.

What are the benefits and drawbacks of limiting participation by using the Health Resouces and Services Administration's Health Professional Shortage Areas (HPSA) designation or Medically Underserved Areas (MUA) designation.

The benefits of using the HRSA HPSAs or MUAs designations is the continuity of standard definitions across federal programs. The creation of a separate definition by the FCC may cause confusion amongst health care providers that operate different federal programs, creatly unnecessary adminsitrative headache. The use of existing definitions allows the FCC to focus on the distribution of Pilot program funding to areas of greatest need given limited resources. This is preferable to the alternative, opening the Pilot Program to proposals from anywhere in the United States.

Should we also, or alternatively, consider limiting participation in the Pilot program only to eligible health care providers that currently provide care to at least a certain percentage of uninsured and underinsured patients or to certain percentage of Medicaid patients?

We strongly recommend that the Pilot program limit participation to health care providers that historically have served a certain percentage or threshold of Medicaid or uninsured patients. Specifically, we suggest a threshold that is greater than 70%. If the purpose of the Pilot is to connect individuals who live in remote communities, have difficulty accessing their health care providers and who cannot afford Internet connectivity, then priority should be given to those providers serving disproportionate share of these Medicaid or uninsured patients. Analysis by the Henry J. Kaiser Family Foundation of 2015 data show that Medicaid provides coverage for almost 1 in four nonelderly indivduals in rural areas. This can be partially attributed to the Medicaid expansion under the Affordable Care Act. While the Medicaid expansion means that more nonelderly adults now have access to care in these rural communities, there are still individuals who are uninsured in rural areas living in states that chose not to expand Medicaid. This is particularly concerning as we know that individuals without insurance coverage are less likely to access health care providers. Dedicated funding to health care providers that largely serve the Medicaid and uninsured populations so that patients have Internet connectivity and technological devices holds great promise for changing health outcomes, reducing future health care expenditures, and patient engagement in the health care system.

Would health care providers still be interested in and be able to participate in the Pilot program if the Pilot program does not fund end-user devices, connected care medical devices, or connected care mobile applications?

As a community mental health center, Hathaway Sycamores would not likely be able to participate in this Pilot program if there was no funding for the end-user devices, connected care mobile applications etc. because of the existing reimbursement structure. In California, community mental health centers that offer mental health services to Medi-Cal beneficiaires under the 1915(b) Freedom of Choice waiver operate under in a Cost Reimbursement system. This means that community mental health centers receive reimbursement (barely) sufficient to cover expenditures for providing medically necessary services to Medi-Cal beneficiaries. There is no dedicated (or extra) funding to invest in end-user devices, connected medical devices, etc. Unless individual donors or philanthropic foundations are willing to fund these purchases, community mental health centers are not able to afford such technology.

Thank you for consideration of our comments.

Sincerely,

Wendy Wang, MPP
Vice President, Public Policy and Advocacy